STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155502	A. BUILDING 00 B. WING	06/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSCENDENT HEALTHCARE OF OWENSVILLE, LLC	HIGHWAY 165 WEST, PO BOX 369 OWENSVILLE, IN47665

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure survey. Survey dates: May 23-27, 31, June 1, 2011 Facility number: 000328 Provider number: 155502 AIM number 100287960 Survey team: Diane Hancock, RN TC Amy Wininger, RN Census bed type: SNF/NF 49 Total 49 Census payor type: Medicare 17 Medicaid 21 Other 11 Total 49 Sample: 13 Supplemental sample: 18 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed on June 3, 2011 by Bev Faulkner, R.N.	F0000	By submittng tthe enclosed matterial we are nott admittng tthe ttrutth or accuracy ofl any speciflc flndings or allegattons. We reserve tthe rightt tto conttestt tthe flndings or allegattons as partt ofl any proceedings and submitt tthese responses pursuantt tto our regulattory obligattons The flacilitty requestt tthatt tthe plan ofl correctton be considered our allegatton ofl compliance eflecttve July 1, 2011 tto tthe annual licensure survey conductted on May23, 2011 tthrough June 1, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			

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	Based on record review and interview, the facility failed to ensure 1 of 1 sampled resident who complained of missing money, in the sample of 13, and 1 of 1 supplemental sample residents who complained of missing money, in the supplemental sample of 18, had the allegations of misappropriation reported to the State Agency. (Residents #14, #51) Findings include: 1. On 5/27/11 at 12:30 P.M., the Administrator provided documentation of an investigation regarding missing money. Resident #51 alleged, on 3/25/11, he had $400 missing from his wallet, which had been in a drawer in his bedside cabinet. A thorough investigation was completed, including interviews with all staff in contact with the resident or potential contact with the money. Other residents were interviewed. The facility was unable to determine if the resident actually had the money and/or who may have taken the money. 2. On 5/27/11 at 12:30 P.M., the Administrator provided documentation of a second investigation regarding missing money. Resident #14 had alleged, on 5/23/11, she was missing $10 to $14 she had in her room. The facility verified with family the resident had the money.	F0225	**F225** **Iti is tihe practice oft tihis ftacilitiy tio assure tihati tihe misappropriation oft residenti ftunds are reportied tio tihe appropriatie agencies as identifted per tihe regulation** ***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** Residentt#51 no longer resides in tthe flacilitty Residentt#14 did have money replaced as identtfled in tthe 2567. There have been no addittonal complaintts relatted tto residentts missing money Please refler tto systtemattc changes relatted tto policy and reporttng mechanisms tto tthe appropriatte sttatte agencies ***Other residents that have the potental to be afiected have been identfied by :*** Pottenttally all residentts could be aflectted However, att tthis ttme tthere have been no addittonal complaintts relatted tto missing flunds ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** The policy relatted tto reporttng ofl abuse or misappropriatton ofl residentt flunds has been reitteratted tto be inclusive ofl all required elementts including nottflcatton ofl appropriatte agency nottflcatton All sttafl has been in-serviced relatted tto tthe policy.	07/01/2011

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	The report indicated the money was replaced while the investigation was being conducted. The investigation was on-going since 5/23/11. 3. On 5/27/11 at 1:07 P.M., during interview, the Administrator and Director of Nurses indicated the alleged misappropriations had not been reported to the State Agency. 3.1-28(c) 3.1-28(e)		***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** A Perflormance Improvementt Tool has been inittatted tthatt will be uttlized tto review tthe proper flollowing ofl tthe abuse policy including nottflcatton ofl tthe appropriatte sttatte agencies. It is tthe Administtrattor's responsibilitty tto assure tthatt tthe appropriatte agencies are nottfled ofl any allegattons. The Administtrattor, or designee, will complette tthis auditt montthly x3, xthen quartterly x3. The Quality Assurance Committee will review tthe ttool att tthe scheduled meettng flollowing tthe completton ofl tthe ttool witth recommendattons as needed. ***The date the systemic changes will be completed:*** July 1, 201	
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure their policy was followed in regards to reporting allegations of misappropriation of resident property, for 1 of 1 sampled resident who complained of missing money, in the sample of 13, and 1 of 1 supplemental sample residents who complained of missing money, in the supplemental sample of 18, in that the allegations were	F0226	**Iti is tihe practice oft tihis ftacilitiy tio assure tihati tihe Administiratior is notifted immediatiely relatied tio allegation oft abuse, neglecti, or misappropriation oft propertiy. The Administiratior is tihen responsible ftor notiftying tihe appropriatie agencies as required. The policy has been reviewed relatied tio tihis inftormation** ***The correcton acton taken fior***	07/01/2011

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	not reported to the state agency. (Residents #51, #14) Findings include: 1. On 5/27/11 at 12:30 P.M., the Administrator provided documentation of an investigation regarding missing money. Resident #51 alleged, on 3/25/11, he had $400 missing from his wallet, which had been in a drawer in his bedside cabinet. A thorough investigation was completed, including interviews with all staff in contact with the resident or potential contact with the money. Other residents were interviewed. The facility was unable to determine if the resident actually had the money and/or who may have taken the money. 2. On 5/27/11 at 12:30 P.M., the Administrator provided documentation of a second investigation regarding missing money. Resident #14 had alleged, on 5/23/11, she was missing $10 to $14 she had in her room. The facility verified with family the resident had the money. The report indicated the money was replaced while the investigation was being conducted. The investigation was on-going since 5/23/11. 3. On 5/27/11 at 1:07 P.M., during interview, the Administrator and Director		***those residents fiound to be afiected by the deficient practce include :*** Residentt#51 no longer resides in tthe flacilittyResidentt#14 has had no flurtther complaintts relatted tto missing money. Please refler tto systtemattc changes relatted tto policy and reporttng mechanisms tto tthe appropriatte sttatte agencies ***Other residents that have the potental to be afiected have been identfied by :*** Pottenttally all residentts could be aflectted As ofl tthis writtng,tthere have been no flurtther complaintts relatted tto missing flunds ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** The policy relatted tto reporttng ofl abuse has been reviewed witth all sttafl members The portton ofl tthe policy relatted tto nottflcatton ofl tthe proper agencies has been reitteratted tto all sttafl members in tthe florm ofl an in-service. ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** A Perflormance Improvementt Tool has been inittatted tthatt will be uttlized tto review tthe abuse policy on an annual basis. The policy would be immediattely amended ifl tthere were tto be changes in tthe regulattons. The Administrattor,or designee, will complette tthis ttool	

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	of Nurses indicated the alleged misappropriations had not been reported to the State Agency. 4. The policy and procedure regarding prohibition of misappropriation of resident property, dated 9/24/2009, was provided by the Administrator on 5/31/11 at 4:05 p.m. The policy and procedure indicated the following: "The facility will have procedures to report all alleged violations and all substantiated incidents to the state agency and to all other required agencies as required..." 3.1-28(a)		annually. An addittonal Perflormance Improvementt Tool has been inittatted tthatt will be uttlized tto review tthe proper flollowing ofl tthe abuse policy including nottflcatton ofl tthe appropriatte sttatte agencies. It is tthe Administtrattor's responsibilitty tto assure tthatt tthe appropriatte agencies are nottfled ofl any allegattons. The Administtrattor, or designee, will complette tthis auditt monttholy, x then quartterly x3. The Quality Assurance Committee will review tthe ttool att tthe scheduled meettng flollowing tthe completton ofl tthe ttool witth recommendattons as needed. ***The date the systemic changes will be completed:*** July 1, 2011	

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F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on observation, interview and record review, the facility failed to comprehensively assess 1 of 13 sampled residents regarding siderail use, and 1 of 1 sampled resident in the total sample of 13 regarding assessing respiratory status before and after a breathing treatment. (Residents #17, #12)	F0272	**F272** **Iti is tihe practice oft tihis ftacilitiy tio assure tihati residentis are assessed appropriatiely in accordance witih stiandards oft nursing practice beftore and after breatihing tireatimentis.n addition, iti is also tihe ftacilitiy's practice tio assure tihati residentis have proper side rail assessmentis based on tihe residentis' individual needs.**	07/01/2011

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	Findings include: 1. The clinical record of Resident #12 was reviewed on 05/25/11 at 10:30 A.M. The record indicated his diagnoses included, but were not limited to, asthma. During observation of the medication pass, on 05/24/11 at 10:10 A.M., LPN [Licensed Practical Nurse] #1 was observed to administer Duoneb [combined respiratory medications] 2.5-0.5 mg/3 ml via nebulizer. LPN #1 was not observed to assess the lung sounds or heart rate of Resident #12 prior to starting the treatment. In an interview, on 05/24/11 at 10:15 A.M., LPN #1 indicated, "I will be back in about 10 minutes." LPN #1 was then observed to exit the room. In an interview, on 05/24/11 at 10:20 A.M., LPN #1 indicated, "When he is done all I do is make sure the nebulizer is back in the bag so it is out of his way." LPN #1 was observed to re-enter the room of Resident #12 on 05/24/11 at 10:30 A.M. LPN #1 was then observed to remove the nebulizer from Resident #12 and place in a storage bag. LPN #1 was not observed to assess the lung sounds or heart rate of Resident #12 before exiting		***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** Residentt#12 is being assessed botth beflore and afler breatthing ttreattmentts.Residentt#17 has had side rail assessmentt updatted tto reflectt residentt's currentt needs witth appropriatte intterventtons ***Other residents that have the potental to be afiected have been identfied by :*** All residentts who receive nebulizer breatthing ttreattmentts are being assessed appropriattely botth beflore and afler tthe breatthing ttreattmentt All residentts tthatt uttlize side rails have been reassessed tto assure tthatt tthe side rails are appropriatte and meett tthe residentts' individual needs ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** A policy has been esttablished relatted tto assessmentts beflore and afler a nebulizer ttreattmentIn additton, a nebulizer flow sheett is being implementted tthatt identtfles appropriatte assessmentts beflore and afler a breatthing ttreattmentt including lung sounds and heartt ratte All nurses have been in-serviced relatted tto tthe policy and implementtatton ofl tthis ttodh additton, an in-service was conductted flor all nursing sttafl relatted tto tthe use ofl side rails The in-service included tthe importtance	

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	the room. In an interview with the DoN, on 05/31/11 at 10:10 A.M., she indicated, "I don't know off the top of my head" what assessment the nurse should do related to administering a breathing treatment. In an interview with the DoN on 05/31/11 at 10:25 A.M., she indicated, "I can't locate a policy and procedure for nebulizer treatments. For assessment, I would think they should listen to lung sounds and check a pulse." The Lippincott Nursing Practice seventh edition was provided by the Nurse Consultant on 05/31/11 at 11:30 A.M. She indicated at that time, "This is our standard." The Lippincott Nursing Practice Chapter 10 Respiratory Function and Therapy page 232 Procedure Guidelines 10-13 Administering Nebulizer Therapy indicated, "Nursing Action Preparatory Phase 1. Monitor the heart rate before and after the treatment for patients using bronchodilator drugs. Rationale 1. Bronchodilators may cause tachycardia (fast heart rate)..." 2. The clinical record of Resident #17 was reviewed on 05/23/11 at 2:15 P.M. The record indicated the diagnoses included, but were not limited to, Senile Dementia.		ofl proper assessmentt witth appropriatte intterventtons and flollowing ofl tthe plan ofl care. ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** A Perflormance Improvementt Tool has been inittatted tthatt will be uttlized tto review tthose residentts witth orders flor breatthing ttreattmentts tto assure tthatt assessmentts are completted botth beflore and afler a breatthing ttreattmentA. An addittonal Perflormance Improvementt ttool has been esttablished tthatt randomly reviews residentts relatted tto side rail assessmentt witth appropriatte intterventtons based on tthe assessmentts These ttools will randomly review 5 residentts The Directtor ofl Nursingor designee, will complette tthe ttools weekly 3x montthly x3, tthen quartterly 1x. Any issues identtfled will be immediattely addressed. The Quality Assurance Committee will review tthe ttools att tthe scheduled meettng flollowing tthe completton ofl tthe ttool witth recommendattons as needed. ***The date the systemic changes will be completed:*** July 1, 2011	

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During initial tour on 05/23/11 at 2:50 P.M., Resident #17 was identified by LPN [Licensed Practical Nurse] #1 as not interviewable, and was observed lying in bed with siderails up bilaterally.

The siderail assessment for Resident #17, dated 04/14/11, indicated, "Determination: side rails are used as an enabler to increase or improved bed mobility. No."

The May 2011 Physician recap had an entry, dated 05/24/11, which indicated, "1/2 side rails to assist with bed mobility."

A Care Plan, dated 12/06/10 and updated 03/06/11, indicated a problem of "At risk for skin breakdown r/t [related to] incontinence," with approaches which included, but were not limited to, "(3)..1/2 side rails to assist with bed mobility."

The CNA [Certified Nursing Assistant] Assignment Sheet provided by LPN #1 indicated, Resident #17 required, "NO rails."

In an interview with LPN #1, on 05/24/11 at 2:45 P.M., she indicated, "[Resident #17] tries to get up sometimes, she has always used siderails."

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F0323 SS=E	3.1-31(a) The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure that siderails spaces between the slats did not exceed 4 3/4 inches in width for 7 of 12 sampled current residents reviewed for siderails, in the sample of 13, and for 13 of 13 supplemental sample residents reviewed for siderails, in the supplemental sample of 18. (Residents #9, #2, #26, #4, #32, #37, #17, #18, #15, #22, #25, #43, #33 #3, #23, #41, #34, #1, #40, #36) Findings include: During observation, on 05/24/11 at 11:15 A.M., a review of all siderails in the facility was conducted. Sixteen [16] residents beds were observed to have siderails which had gaps between the slats that measured 7 3/4 inches in width. Sampled Residents #2, #26, #4, #32,#37, and supplemental sample Residents # 18, #15, #22, #25, #43, #33 #3, #23, #41, #34, #1 resided in those beds. Three [3] resident beds were observed to have siderails which had gaps between the	F0323	**F323** **Iti is tihe practice oft tihis ftacilitiy tio assure tihati residentis tihati utilize side rails are assessed properly and tihati tihe side rails are spaced appropriatiely tio assisti witih tihe prevention oft any incidentis relatied tio side rails** ***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** Residentts#9, #2, #26, #4, #32, #37, #17, #18, #15, #22, #25, #43, #33, #3, #23, #41, #34, #1, #40, and #36 have all been reassessed relatted tto side rails. For tthose residentts tthatt conttnue tto uttlize side rails,seitther a bolstter device is in place or tthe side rail has been covered witth a mesh side rail cover tto promotte safletty ***Other residents that have the potental to be afiected have been identfied by :*** All residentts tthatt uttlize side rails have been reassessed. All residentts tthatt uttlize side rails have had bed bolstters applied or a mesh side rail cover tto promotte safletty ***The measures or systematc changes that have been put into place to ensure that the deficient***	07/01/2011

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	slats that measured 7 7/8 inches in width. Sampled Resident #17 and supplemental sample Residents #40 and #36 resided in those beds.		***practce does not recur include :*** Att tthe ttme tthis was broughtt tto tthe attentton ofl tthe flacilitty by tthe surveyors, tthe flacilitty immediattely putt a monittoring systtem in place tto assure tthatt tthe residentts remained safle Also, side rail assessmentts were completted and eitther bed bolstters or mesh side rail covers were ordered tto use tto assure tthatt tthe side rails were witthin regulattory compliance. The implementtatton ofl tthe side rail bolstters ofl mesh covers was in place prior tto tthe end ofl survey. As partt ofl tthe systtemattc change, ifl an assessmentt identtfles tthe usage ofl a side rajltthe side rail will eitther be witthin accepttable measurementt guidelines, or a side rail bolstter or mesh cover will be uttlized. The sttafl has been in-serviced relatted tto tthe use ofl side rails and ttheir safletty ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** A Perflormance Improvementt ttool has been esttablished tthatt randomly reviews residentts who uttlize side rails tto assure tthatt tthey are safle and witthin accepttable guidelinesThese ttools will randomly review5 residentts The Directtor ofl Nursing or designee, will complette tthe ttools weekly x3, montthly x3, tthen quartterly x3. Any issues identtfled will be immediattely addressed The Qualitty Assurance Committee will	

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	155502	A. BUILDING 00 B. WING	06/01/2011

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			review tthe ttools att tthe scheduled meettng flollowing tthe completton ofl tthe ttool witth recommendattons as needed. ***The date the systemic changes will be completed:*** July 1, 2011	

Resident #9's clinical record was reviewed on 5/24/11 at 11:00 a.m. The resident's record had a siderail assessment, dated 4/11/11, that indicated the following: "Side rails/mattress have been assessed and have no gaps wide enough to entrap a resident's head or body." The documentation indicated, with a check mark in the yes column, that this had been done. The rails were measured on 5/24/11 at 11:15 a.m. and the gap measured 7 and 3/4 inches.

The policy and procedure for side rail safety [no date], provided by the DoN [Director of Nursing] on 05/31/11 at 11:20 A.M., indicated, "Policy: ..1. The bars within the bed rails should be closely spaced to prevent a patients head from passing through the opening and becoming entrapped...Appendix 2: Bed Rails-Intended Purpose and Potential Risks...Potential Risks of Bed Rails 1. Create a source of known morbidity and mortality such as: Strangling, suffocation, serious bodily injury or death when patients or parts of their bodies are caught

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	between rails, the openings of the rails, or between the bed rails and mattress." In an interview with the facility owner, on 05/25/11 at 9:30 A.M., he indicated he was "not aware there was a guideline regarding the space between the slats on the siderails." The Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment-Guidance for Industry and FDA Staff issued March 10, 2006 indicates the FDA (Food and Drug Administration) recommends openings within the rail, between rail supports, under the rail or next to a single rail support and between the rail and mattress should be small enough to prevent the head from entering or being entrapped. The " Hospital Bed Safety WorkGroup (HBSW) " and the "International Electrotechnical Commission (IEC)" along with the FDA recommend the space be less than 4 ¾ inches. The FDA recommends the space under the rail- at the ends of the rail be small enough to prevent neck entrapment. The HBSW and the IEC along with the FDA recommend this space be less than 2 3/8 inches and greater than a 60 degree angle. 3.1-45(a)(1)			

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure 1 of 8 sampled residents reviewed for psychoactive medications, in the sample of 13, was reviewed for excessive doses following a hospitalization, in that the resident was placed on higher doses than prior to the hospitalization without review and adjustment upon return from the hospital. (Resident #37) Finding includes:	F0329	**F329** **Iti is tihe practice oft tihis ftacilitiy tio assure tihati residentis are assessed appropriatiely relatied tio psychoactive medication usage.** ***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** Residentt#37 has been psychoacttve medicatton has been reviewed and tthe medicattons have been adjustted in accordance witth tthe physician's orders. ***Other residents that have the potental to be afiected have been***	07/01/2011

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	Resident #37's clinical record was reviewed on 5/27/11 at 9:30 a.m. The resident was admitted to the facility 11/4/06 with diagnoses including, but not limited to, senile dementia, hypertension with episodes of lower blood pressure, insomnia, restless leg syndrome, hypothyroidism, and syncope. Physician's orders, dated 4/26/11 upon discharge from the hospital, included, but were not limited to, the following sedating medications: Flexeril 10 milligrams [mg] [muscle relaxant] by mouth at bedtime, Xanax [anti-anxiety medication] 1 mg by mouth at bedtime, and Ambien 5 mg [sleeping medication] by mouth nightly. Review of orders prior to the hospitalization, dated 3/30/11, indicated the following routine orders for sedating medications: Xanax 0.5 mg one tablet by mouth at bedtime, Flexeril 10 mg one tablet by mouth once daily [for restless leg syndrome]. There was no order for Ambien. Review of the Pharmacy Consultant Medication Regimen Review, dated 4/15/11, indicated notes "GDR [gradual dose reduction] repeat," "Tramadol DC'd [discontinued]," D/C Ambien." The Director of Nurses [DoN] provided, on 5/31/11 at 11:00 a.m., copies of		***identfied by :*** All residentts tthatt receive psychottropic medicattons have been reviewed witth reducttons as appropriatte in correlatton witth tthe physicians' orders. ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** Nurses have been in-serviced relatted tto assessing residentts upon retturn flrom hospittalizatton relatted tto any adjusttmentts tthatt may have occurred witth ttheir psychoacttve medicattons All residentts tthatt uttlize psychoacttve medicattons are reviewed on admission or readmission, or ifl tthere is a signiflcantt change or decline In additton, all residentts tthatt uttlize psychottropic medicattons are reviewed att leastt quartterly flor possible reductton by tthe intterdisciplinary tteam The consulttng pharmacistt also works witth tthe flacilitty tto assure tthatt reducttons are occurring appropriattely unless tthe physician identtfles tthatt tthe residentt is nott appropriatte flor a reductton based on tthe residentt's conditton/diagnosis and/or pastt histtory ofl flailed reducttons ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** A Perflormance Improvementt ttool has been esttablished tthatt randomly	

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	pharmacy notes to the physician dated 2/9/11 and 4/15/11. The notes recommended a reduction of Xanax from 0.5 mg every bedtime to 0.25 mg every bedtime. The 2/9/11 note was responded to by the physician as "disagree" due to the physician's assessment it was the lowest clinically effective dose. The 4/15/11 recommendation had not been responded to by the physician. The resident had been hospitalized from 4/22/11 to 4/26/11 and returned on 1 mg of Xanax at bedtime. Nurses' notes included, but were not limited to, the following: "5/5/11 1400 [2:00 p.m.] ...noted pt. [patient] to lean to left significantly [with] poor endurance to all activities, significant decline noted since hospitalization shuffling steps noted [with] gait training prior level of function..." 5/12/11 1400 "...B/P [blood pressure] 100/60, significant [decline] noted since hospitalization noted BLE [bilateral lower extremity edema, shuffling steps noted [with] gait, poor level of functioning, poor endurance, PT [Physical Therapy noted to lean to the left..." The resident had the following care plans, all dated 5/6/11: Problem: "Resident has hx [history] of		reviews residentts who have orders flor psychoacttve medicattons tto assure tthatt tthey are assessed and reduced properly in accordance witth tthe guidelines.This ttool will randomly review 5 residentts The Directtor ofl Nursingor designee, will complette tthe ttool weekly x3, montthly x3, tthen quartterly x1. Any issues identtfled will be immediattely addressed. The Qualitty Assurance Committee will review tthe ttool att tthe scheduled meettng flollowing tthe completton ofl tthe ttool witth recommendattons as needed. ***The date the systemic changes will be completed:*** ***July 1, 2011***	

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	experiencing changes in sleep patterns AEB [as evidenced by] episodes of insomnia." Approaches included the following: "1. Attempt to limit naps to early part of day as needed. 2. Offer comfort measures at HS [hour of sleep] to promote sleep (e.g. [for example] warm decaffeinated beverages, backrub, soft music) and reduce excess stimulation. 3. Request psych [psychiatric] consult from physician if condition persists." Problem: "Potential for side effects r/t [related to] use of antianxiety." Approaches: 1. Observe for side effects from use of antianxiety med, lethargy. 2. Notify MD as needed. 3. Work with MD to provide lowest most therapeutic dose." Problem: "At risk for side effects from use of hypnotic med [medication]." Approaches: "Observe for side effects from use of hypnotic med. 2. Notify MD as needed. 3. Work with MD to provide lowest most therapeutic dose." On 5/31/11 at 10:45 a.m., the Director of Nurses [DoN] was interviewed. She indicated the resident was hospitalized from 4/22/11 to 4/26/11 and returned with the orders for the Xanax 1 mg at bedtime and the Ambien 5 mg at bedtime. She indicated the resident's Ambien had been discontinued prior to the hospital visit and			

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	the Xanax had been only 0.5 mg at bedtime prior to the hospital visit. She indicated the hospital must not have used the current physician's order information sent with the resident on 4/22/11 to determine the resident's medications and had sent the resident back with previously ordered doses that had been discontinued prior to the hospitalization. She indicated the nurses were supposed to review all medications upon return from the hospital, but these had been missed. She indicated she would be notifying the physician. On 5/31/11 at 3:30 p.m., the DoN indicated the physician had discontinued the Ambien and lowered the Xanax dose to 0.5 mg at bedtime. 3.1-48(a)(1) 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(5) 3.1-48(a)(6)			
F0365 SS=D	Each resident receives and the facility provides food prepared in a form designed to meet individual needs.			

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	Based on observation, record review and interview, the facility failed to ensure 1 of 12 sampled current residents observed during meal service, in the sample of 13, and 1 of 1 supplemental sample residents observed during meal service, in the supplemental sample of 18, received their food in mechanical soft or pureed form as determined by their needs and physicians' orders. (Residents #22, #9) Findings include: 1. Resident #22 was observed being fed her evening meal by CNA #1, on 5/26/11 at 5:20 p.m. Observed on the meal tray were three food items on a plate in pureed form. A small bowl with chunks of pears was observed on the tray as well. CNA #1 indicated the kitchen had sent the wrong fruit and she was going to replace it with pureed fruit. The resident's tray card was reviewed at that time and indicated she was to receive a pureed diet. The resident's physician's orders were reviewed on 6/1/11 at 10:05 a.m., and indicated the most recent signed physician's orders, dated 3/31/11, were for a pureed diet. 2. On 5/31/11 at 2:05 p.m., Resident #9 was observed to be in his room finishing his lunch. The food on the plate included, but was not limited to, some noodles with	F0365	**F365** **Iti is tihe practice oft tihis ftacilitiy tio assure tihati residentis receive all meals and supplementis in accordance witih tihe physician's orders.** ***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** Residentts#22 and #9 are receiving ttheir meals att tthe consisttency order by ttheir attending physician ***Other residents that have the potental to be afiected have been identfied by :*** All residentts who have diett orders tthatt are ofl alttered consisttency have been reviewed and are receiving ttheir meals in accordance witth tthe physicians' orders. ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** An in-service has been conductted witth tthe diettary departtmentt relatted tto serving flood consisttencies in accordance witth tthe physicians' order. The in-service includes flollowing tthe spread sheett when serving tto assure tthatt each flood ittem is served as ordered In additton, nursing has been in-serviced relatted tto assuring tthatt tthey observe tthe diettary card tto assure tthatt whatt is being served tto tthe residentts is consisttentt witth tthe diett identtfled on tthe diettary card Serving will be monittored via a	07/01/2011

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	brown gravy. To the side of the plate, on the plastic tray, were observed 6 chunks of meat, greater than 1/2 inch wide. The resident indicated he had placed them there because he could not eat them. The resident's tray card was reviewed at that time and indicated he was to receive a mechanical soft diet. The resident's physician's orders, reviewed on 6/1/11 at 10:00 a.m., indicated he was to receive a mechanical soft diet. 3. The Diet Spreadsheet for 5/31/11 lunch was provided by the Dietary Manager on 6/1/11 at 10:06 a.m. The spreadsheet indicated the mechanical soft diets were to receive braised beef tips "ground" on 5/31/11 at the noon meal. 3.1-21(a)(3)		Perflormance Improvementt Tool as identtfled below. ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** A Perflormance Improvementt ttool has been esttablished tthatt randomly reviews residentts who have alttered diett consisttency orders. This ttool will randomly review 5 residentts during tthe service line The Diettary Manager, or designee, will complette tthe ttool weekly x3, montthly x3, tthen quartterly x3. Any issues identtfled will be immediattely addressed The Qualitty Assurance Committee will review tthe ttool att tthe scheduled meettng flollowing tthe completton ofl tthe ttool witth recommendattons as needed. ***The date the systemic changes will be completed:*** July 1, 2011	
F0371 SS=E	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure that sour cream was held and served at the proper temperature, for 5 of 5 sampled residents whose trays were served	F0371	**It is the practice of this facility to assure that all meals are served to residents within appropriate temperature guidelines.** ***The correction action taken for those***	07/01/2011

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	(Residents #37, #21, #6, #12, #17), in a sample of 13, and for 5 of 5 supplemental sample residents whose trays were served (#27, #1, #39, #46, #45), in a supplemental sample of 18. The sour cream was not kept at appropriate temperature during the tray service. Findings include: During observation of kitchen staff checking food temperatures, prior to dining room service, on 05/25/11 at 11:25 A.M., Cook #1 was observed to check the temperature of sour cream located near the steam table. The sour cream was observed to be on ice in individual souffle cups. During an interview at that time, Cook #1 indicated the temperature of the sour cream was 52 degrees Fahrenheit. Cook #1 was then observed to obtain a second thermometer and check the temperature of the sour cream. During an interview at that time, Cook #1 indicated the temperature of the sour cream was 50 degrees Fahrenheit. During an interview at the time of service, Cook #1 indicated the sour cream had been out of the refrigerator and on the serving table for about 25 minutes. Cook #1, she indicated she had not tested the temperature of the sour cream before		***residents found to be affected by the deficient practice include:*** Residents #37, #21, #6, #12, #17, #27, #1, #39, #46, and #45 are receiving all meals at appropriate temperatures. ***Other residents that have the potential to be affected have been identified by:*** Because of the systems that have been implemented, all residents are receiving meals at the appropriate temperatures. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The dietary staff has been in-serviced to reiterate the practice of taking temperatures of the food prior to serving the food. A policy has been implemented related to the proper monitoring of food temperatures. Please refer to monitoring systems to assure compliance with food temperatures. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement tool has been established that randomly reviews food temperatures. This tool will randomly review test trays and verify that temperature logs are complete. The Dietary Manager, or designee, will complete the tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately addressed. The Quality	

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	serving out the room trays. Cook #1 further indicated, "I should have, but I didn't...both hall carts were served...with sour cream on them." A blank Food Temperature Record was provided by the Health Facility Administrator [HFA] on 05/31/11 at 11:00 A.M. The HFA indicated the facility had "no specific policy" for checking food temperatures, but the Food Temperature Record was used as a guide. The HFA further indicated, "We check food temperatures at the beginning and midpoint of food service." In an interview with the DoN [Director of Nursing], on 06/01/11 at 9:30 A.M., she indicated 10 residents were served the sour cream on room trays on 5/25/11. (Residents #37, #21, #6, #12, #17, #27, #1, #39, #46, #45) 3.1-21(i)(2) 3.1-21(i)(3)		Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** July 1, 2011	
F0387 SS=D	The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.			

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	Based on interview and record review, the facility failed to ensure 2 of 13 sampled residents were visited by their physician in a timely manner, in that Resident #17 was not visited by the attending physician for 83 days and Resident #21 was not visited by the physician for 98 days. Findings include: 1. The clinical record of Resident #17 was reviewed on 05/23/11 at 2:15 P.M. The Physician Progress Notes, dated 03/09/11, indicated Physician #1 visited with Resident #17 on that day. In an interview with the DoN [Director of Nursing] on 05/31/11 at 2:50 P.M., she indicated, "I called the office and verified the Dr. has not seen her since 03/09/11." (A total of 83 days since last visit.) 2. The clinical record of Resident #21 was reviewed on 05/25/11 at 11:00 A.M. The Physician Progress Notes, dated 02/17/11, indicated Physician #2 visited with Resident #21 on that day. In an interview with DoN, on 05/26/11 at 11:30 A.M., she indicated, Resident #21 had not been seen by Physician #2 since 2/17/11. (A total of 98 days)	F0387	**F387 It is the practice of this facility to assure that physicians visit in a timely manner in accordance with the regulations.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #17 and #21 have both had their physician orders signed. ***Other residents that have the potential to be affected have been identified by:*** All residents have been reviewed to assure that their physician orders have been signed in a timely manner. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** A tickler system has been established to identify when physicians are due to visit their residents. The physicians will be contacted at least 2 weeks prior to their due date to remind them that it is time for a visit. We will continue to communicate with the physician related to timely visits. An in-service has been conducted for nurses related to the importance of assuring that when the physicians visit that they verify that they have signed all of their orders before leaving. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement tool has been	07/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155502	A. BUILDING 00 B. WING	06/01/2011

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	In an interview with the DoN on 06/01/11 at 12:25 P.M., she indicated, "There was no system in place before to track physician visits." 3.1-22(d)(1)		established that randomly reviews residents for timeliness of signed physician orders. This tool will randomly review 5 residents. The Director of Nursing, or designee, will complete the tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** July 1, 2011	
F0458 SS=D	Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. Based on observation, record review and interview, the facility failed to ensure 1 of 1 resident room (#31) out of 33 resident rooms, measured at least 80 square feet per resident. The room was set up to house 3 residents and measured 15 feet 11 inches long by 13 feet 3 inches wide. This resulted in 70.29 square feet per resident. Finding includes: *Room #31 [certified for Title 18/19 SNF/NF] was observed, on 5/23/11 at 3:00 P.M., to have three beds set up, to house three residents.	F0458	F458It is the practice of Transcendent Healthcare to assure that a resident's room meets square footage requirements unless a written waiver is in place thru the appropriate agency.The correction action taken for those residents found to be affected by the deficient practice include:A waiver was granted during the last annual survey for room #31. A new waiver will be applied for through the Indiana State Department of Health.Other residents that have the potential to be affected have been identified by:There are no other rooms in the facility that are affected by this cited deficiency.The measures of systematic changes that have	07/01/2011

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	The measurements of Room #31 were 15 feet 11 inches long by 13 feet 3 inches wide. This calculated to be 70.29 square feet per resident. On 5/23/11 at 9:15 a.m., the Administrator provided information regarding the room waiver and indicated the facility intended to keep the room set up to house three residents. 3.1-19(l)(2)		been put into place to ensure that the deficient practice does not recur include:A waiver has been requested through the Indiana State Department of Health.The corrective action taken to monitor performance to assure compliance through quality assurance is:A waiver has been requested throught the Indiana State Department of Health.The date the systemic changes will be completed:July 1, 2011	